PRESCRIPTION REFILL REQUEST SHEET

☐ Waiting to be seen ☐ Chart only for refill | Provider's name:

Part I - Patient or Legal Guardian

1. Patient's name (Last, First, Middle)	2. Family member prefix	3. Sponsor's social security number

4. Prescription refill information

a. Medication	*b.* Dose	*c.* Reason for taking	*d.* Side effects	*e.* Are the side effects new?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

5. Date of last menstrual period	6. Date of last Pap test

7. Allergies you have to medications

8. Other allergies

9. Patient's acknowledgements and agreements. My signature below in item 18b indicates that I acknowledge the following:

a. It is a requirement to leave my medical records with the provider for review.
b. My primary care manager (PCM) or designee will review my chart for medication refill.
c. If my provider has any questions or concerns about my medications, he or she may elect to defer my refill until I can be seen.
d. I will return to the clinic during normal business hours, prior to going to the pharmacy, to verify the refill status of my medications.
e. I (☐ agree) (☐ do not agree) to accept an equivalent medication if my medication is not available on the formulary. *If I do not agree to accept an equivalent medication and my requested medication is not available on the formulary, I understand that it cannot be refilled unless I see a provider.*
f. Refilled medications will be available for pick up the next working day and will remain available in the pharmacy for 7 days prior to being reshelved. Once reshelved, they will no longer be available to me without going through my PCM.

10a. Patient's or legal guardian's printed name	10b. Signature	10c. Date	10d. Time

Part II - Provider

11. Vital signs:	11a. Respiration	11b. Pulse	11c. Blood Pressure	12. Smoker? ☐ Yes ☐ No	13. Nursing Initials

14. Decisions and instructions

☐ I have ordered your medication to be refilled for _____ days.
☐ I have a few questions concerning the medication you are requesting, its dosage or its side effects. For your safety, I have not ordered your medication to be refilled at this time. Please consider staying for a walk-in visit.
☐ You should return for a follow up visit:
☐ If you have problems, concerns or side effects with this medication.
☐ In ____ weeks. ☐ In ____ months.

☐ Other:

15a. Provider's printed name or stamp	15b. Signature	15c. Date